MEDICATION ADMINISTRATION RECORD

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
Ondansetron 8mg P.O. BID x 10 days, 1/14/99–1/24/99 Siddiq/CL	1100															A	A	A	A	A	A	[illegible]	4	A	A				
	1900															M	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	A		A					
Robaxin 1gm P.O. BID x 10 DAYS 1/14/99–1/24/99 Siddiq CL	1100															A	A	A	A	A	A	A	[illegible]	A	A				
	1900															M	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			A					

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 1/1/99 THROUGH 1/31/99

Physician

Alt. Physician J. Siddiq

Allergies Motrin

Telephone No.

Alt. Telephone

Rehabilitative Potential

Medical Record No.

Diagnosis

Medicaid Number

Medicare Number

Complete Entries Checked By: C. Lewis Title: RN Date: 1/14

PATIENT [illegible]

PATIENT CODE | ROOM NO. | BED | FACILITY

MEDICATION ADMINISTRATION RECORD

MEDICATIONS	HOUR	1–28
[illegible] 50mg tid x 15 d [illegible]/98 – 6/10/98 Dr. Siddiq	0400 1100 1700	[illegible initials, days 1–10]
[illegible] 4mg tid x 15 d [illegible]/98 – 6/10/98 Dr. Siddiq	0400 1100 1700	[illegible initials, days 1–10]

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 06/01/98 THROUGH 06/30/98

Physician

Alt. Physician

Allergies

Telephone No.

Alt. Telephone

Medical Record N

Rehabilitative Potential

Diagnosis

Medicaid Number

Medicare Number

Complete Entries Checked By: B. [illegible] Title: RN Date: [illegible]

PATIENT [illegible]

PATIENT CODE [illegible]

ROOM NO.

BED

FACIL

MEDICATION ADMINISTRATION RECORD

MEDICATION	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
Diflucan 50mg po tid x 15 d Siddiq/LW 5-26-98 → 6-10-98	0400 1100 1900																										[illegible]	[illegible]	[illegible]
[illegible] 1gm po tid x 15 d Siddiq/LW 5-26-98 → 6-10-98	0400 1100 1900																										[illegible]	[illegible]	[illegible]

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR

Physician: Siddiq

Alt. Physician

Allergies

Telephone No.

Alt. Telephone

Medical Record N

Rehabilitative Potential

Diagnosis

Medicaid Number

Complete Entries Checked

By: [illegible] Title: [illegible] Date: 5-

PATIENT: Fountain Jones

PATIENT CODE: 152157 | ROOM NO. | BED | FACIL: [illegible]

MEDICATION ADMINISTRATION RECORD

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
Vistaril T po TID x 10 days 11-3-97 → 11-13-97 Siddiq[illegible]	[illegible]	→	→	A	[illegible]	[illegible]	A	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]																	
	[illegible]	→	→	[illegible]	[illegible]	[illegible]	[illegible]	A	A	A	A	A	A																
	[illegible]	→	→	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	A	[illegible]		A																

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 11-1-97 THROUGH 11-30-97

Physician

Alt. Physician

Allergies Motrin

Telephone No.

Alt. Telephone

Rehabilitative Potential

Medical Record No. 152151

Diagnosis

Medicaid Number

Medicare Number

Complete Entries Checked By: Washington Title: LPN Date: 11-3-[illegible]

PATIENT Fountain Tony

PATIENT CODE 152150

ROOM NO. [illegible]

BED

FACIL[illegible]

MEDICATION ADMINISTRATION RECORD

MEDICATIONS	HOUR	1–28
Robaxin 1gm tid x 10 days 4/13 → 4/23/98 Siddiq	0400 1100 1700	[initials]
[illegible] tid x 10 [illegible] Siddiq	0400 1100 1700	[initials]
Naprosyn 500mg tid x 10 days 4/16 → 4/26/98 Siddiq	0400 1100 1700	time Δ
Naprosyn 500mg po TID x [illegible] days 4/[illegible]/98-4/26/98 Dr. Siddiq	1100 1700 2100	[initials]
Indocin 50mg po TID x 10 days Desiddiq 4/27/98 → 5/7/98	0400 1100 1700	
Robaxin 1gm po TID x 10 days Desiddiq 4/27/98 to 5/7/98	1100 1700 2100	
Indocin 50mg po tid x 10 days 4/27/98 → 5/8/98 Desiddiq/RBS	0400 1100 1700	
Robaxin 1 Gm po tid x 10 days 4/27/98 → 5/8/98 Desiddiq/RBS	0400 1100 1700	

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 4-1-98 THROUGH 4-30-98

Physician

Alt. Physician

Allergies Motrin

Telephone No.

Alt. Telephone

Medical Record N 152157-

Rehabilitative Potential

Diagnosis

Medicaid Number

Complete Entries Checked By: [signature] Title: [illegible] Date: 4/1

PATIENT Fountain, [illegible]

PATIENT CODE 152157

ROOM NO.

BED

FACIL

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

Please send this form with the Authorization Letter to the service provider

Form must be Complete and Legible. You must Type – Print at time of the Appointment

PHS

RECEIVED SEP 21 2006

DEMOGRAPHICS

Site Name & Number: Staton 843

Site Phone #: (334) 567-1548

Site Fax #: (334) 567-1538

Will there be a charge? ☐ Yes ☐ No

Sex: ☐ Male ☐ Female

Patient Name: (Last, First) Fountain, Terry

Alias: (Last, First)

Inmate #: 152157

SS Number: 416-98-8129

Date: (mm/dd/yy) 09/19/06

Date of Birth: (mm/dd/yy) 12/6/63

PHS Custody Date: (mm/dd/yy) 10/8/05

Potential Release Date: (mm/dd/yy) 3/25/07

Responsible party: ☐ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans:) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental

Paul Corbett, MD

Facility Medical Director Signature and Date:

Paul Corbett 9/20/06

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☐ Office visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)

☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☐ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) ___/___/___

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy

Number of Visits/Treatments: ____ ☐ Other:

Specialist referred to: Dr. Jackson

Type of Consultation, Treatment, Procedure or Surgery:

Colonoscopy

Diagnosis: Persistent lower GI bleed

ICD-9 code:

You must include copies of pertinent reports such as lab results, X-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

History of Illness/Injury/symptome with Date of Onset:

42 yo WF c/o rectal bleeding since 2/06. Pt is concerned about ↑ bleeding in last few weeks. He has both Melena & Hematochezia.

Results of a complaint directed physical examination:

Rectal mass
Heme ⊕ stool

Previous treatment and response (including medications):

Heme ⊕ on Rectal Exam since 3/21/06
LFT's are back to Normal

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information.

☑ Offsite Service Recommended and Authorized

Date resubmitted: ___/___/___

Regional Medical Director Signature, printed name and date required:

9/20/06

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type: S Non-Cert:

CPT code: 45379

UR Auth #: 16521638

8/19/06 TM Faxed

09/19/2006 15:33 FAX 95677167 STATON 008

PHS

Form must be Complete and Legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

RECEIVED SEP 20 2006

DEMOGRAPHICS

Site Name & Number: Staton 843

Site Phone #: (334) 567-1548

Site Fax #: (334) 567-1538

Will there be a charge? ☒ Yes ☐ No

Sex: ☒ Male ☐ Female

Patient Name: (Last, First) Fountain, Terry

Alias: (Last, First) Fountain, Tony

Inmate # 152157

SS Number 416-98-8129

Date: (mm/dd/yy) 08/19/06

Date of Birth: (mm/dd/yy) 2/22/63

PHS Custody Date: (mm/dd/yy) 10/18/05

Potential Release Date: (mm/dd/yy) 5/25/07

Responsible party: ☒ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

T2549

CLINICAL DATA

Requesting Provider: ☒ Physician ☐ NP, PA ☐ Dental

Terri Corbett, MD

Facility Medical Director Signature and Date:

Carlos 9/20/06

☐ Service/meets criteria for "approval via protocol"

Place a check mark(✓) in the Service Type requested (one only) and complete additional applicable fields.

☐ Office visit (OV) ☐ X-ray (XR) ☒ Scheduled Admission (SA)

☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☐ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) ___/___/___

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy

Number of Visits/Treatments: ____ ☐ Other: ____

Specialist referred to: Dr. Jackson BMCS

Type of Consultation, Treatment, Procedure or Surgery:

Colonoscopy 772.4

Diagnosis: Persistent bowel bleed

ICD-9 code:

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

History of illness/injury/symptoms with Date of Onset:

42 yo WM c/o rectal bleeding since 2/06. Pt is concerned about ↑ bleeding in last few weeks. He has both Melena & Hematochezia

Results of a complaint directed physical examination:

DRE Rectal mass Heme ⊕ stool

Previous treatment and response (including medications):

Heme ⊕ on Rectal Exam since 3/24/06

LFT's are back to Normal

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information.

☒ Offsite Service Recommended and Authorized

Date resubmitted: ___/___/___

Regional Medical Director Signature, printed name and date required:

9/20/06

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type: S Med Class: OS

CPT code: 45379

UR Auth #: 11521638

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

Please send this f... Form must be Complete and Legible. You must Type ... with the Authorization Letter to the service provider. Print ... e time of the Appointment

PHS

DEMOGRAPHICS

Site Name & Number: Staton 843

Site Phone #: (334) 567-1548

Site Fax #: (334) 567-1538

Will there be a charge? ☐ Yes ☐ No

Sex: ☐ Male ☐ Female

Patient Name: (Last, First,) Fountain, Terry

Alias: (Last, First,)

Inmate # 152157

SS Number 416-98-8129

Date: (mm/dd/yy) 08/29/06

Date of Birth: (mm/dd/yy) 8/26/63

PHS Custody Date: (mm/dd/yy) 10/8/05

Potential Release Date: (mm/dd/yy) 3/25/07

Responsible party: ☐ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

CLINICAL DATA

Requesting Provider: ☒ Physician ☐ NP, PA ☐ Dental

Paul Corbett, MD

Facility Medical Director Signature and Date: Paul Corbett 8/29/06

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☒ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)

☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☐ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) ___/___/___

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy

Number of Visits/Treatments: _____ ☐ Other:_____

Specialist referred to: Dr. Jackson

Type of Consultation, Treatment, Procedure or Surgery: Colonoscopy Dx

Diagnosis: Persistent lower GI bleed

ICD-9 code:

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

History of illness/injury/sypmtoms with Date of Onset:

42 YOM c c/o Rectal bleeding since 2/06. Pt - is concerned about ↑ bleeding in last few weeks. He has both Melena & Hematochezia

Results of a complaint directed physical examination:

Rectal many Heme ⊕ stool

Previous treatment and response (including medications):

Heme ⊕ on Rectal Exam since 3/21/06

LFT's are back to Normal

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information.

☐ Offsite Service Recommended and Authorized

Date resubmitted: ___/___/___

Regional Medical Director Signature, printed name and date required:

Do not write below this line. For Case Manager and Corporate Data Entry ONLY. ___/___/___ (mm/dd/yy)

Cert Type: Med Class:

CPT code:

UR Auth #: 16521638

05a - UM Referral review form

8/29/06 TM Faxed 9/21/06 Pended

Please send this form w[illegible] Must be Complete and Legible. You must type or fax Authorization Letter to the service provider 5 the of the Appointment

RECEIVED

DEMOGRAPHICS

Site Name & Number: 843 - STATON

Patient Name: (Last, First) Fountain, Tony.

Date: (mm/dd/yy) 8 7 0 3 1 0 6

Site Phone #: 334-567-1548

Alias: (Last, First)

Date of Birth: (mm/dd/yy) 8/26/63

Site Fax #: 334-567-7167

Inmate #: 152157 DCC

PHS Custody Date: (mm/dd/yy) 10/28/05

Will there be a change? Yes / No

Sex: Male / Female

SS Number: 416-98-8129

Potential Release Date: (mm/dd/yy) 3/25/07

Responsible party: PHS / Auto Ins. / Health Ins. (Includes Medicare/Medicaid/Managed Care alternative plans) / Other, be specific (Includes Workers, Medicaid and Veterans Administration Services)

CLINICAL DATA

Requesting Provider: Physician / NP/PA / Dental

J. M. Peasant, Sr., M.D.

Facility Medical Director Signature and Date:

J. M. Peasant 7/13/06

Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

Office Visit (OV) / X-ray (XR) / Scheduled Admission (SA)

Outpatient Surgery (OS) / Dialysis (DI)

Routine / Urgent

Estimated Date of Service (mm/dd/yy) __/__/__

(This starts the approval window for the "upon authorization period")

Multiple Visits/Treatments: Radiation therapy / Chemotherapy / Other

Number of Visits/Treatments: ____

Specialist referred to:

Type of Consultation, Treatment, Procedure or Surgery:

Evaluate for ? colorectal cancer OFFICE Visit

Diagnosis: Rectal bleeding

ICD-9 code:

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

Pertinent Documents have been attached and faxed.

History of illness/injury/symptoms with Date of Onset:

4/2yo BM c/o rectal bleeding off and on for 3-4 months. Pt denies abd pain, fissures or hemorrhoids. No hx of anal disease

Results of a complaint directed physical examination:

Stable Hgb + 3/21/06 + 6/6/06 on rectal exam. Prostate 2+ - No hard Nodules. ABN LFTs AST - 44 ALT - 119 7/3/06

Hep A, B, + C - all - Bili + Alk - WL

Previous treatment and response (including medications):

08/2006 Patient taking Prevacid 30mg QDS

Q INA therapy in past

Dr. Peasant wanted colonoscopy to be

For security and safety, please do not inform patient of possible follow-up appointments

rectal bleeding History

UM DETERMINATION:

Alternative Treatment Plan (explain below):

More Information Required: (See Attached)

Form/Omitted with requested information.

Offsite Service Recommended and Authorized

Please clarify are you requesting OV & referral or the actual colonoscopy procedure?

Date reauthorized: __/__/__

Regional Medical Director Signature, printed name and date required:

7/17/06

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type: Med Class: CPT code: UR Auth #:

Obsn - UM Referral review form

faxed 7/17/06 JM

Let's consider weight significance as Barrett's esophagus.

? Why ↑ IN LFTs ? Was patient on INH?

7/17/06

LabCorp Birmingham
1801 First Avenue South, Birmingham, AL 35233-0000
Phone: 205-581-3500

SPECIMEN	TYPE	PRIMARY LAB	REPORT STATUS	
144-205-5298-0	S	MB	COMPLETE	Page #: 2

ADDITIONAL INFORMATION

SCC

FASTING: Y
DOB: 8/24/1963

PATIENT NAME	SEX	AGE(YR./MOS.)
FOUNTAIN,TONY	M	42 / 9

PT. ADD.:

DATE OF COLLECTION	TIME	DATE RECEIVED	DATE REPORTED	TIME	
5/24/2006	8:43	5/24/2006	5/25/2006	7:46	5152

CLINICAL INFORMATION
CD- 41147610691

PHYSICIAN ID.	PATIENT ID.
PEASANT J	152157

ACCOUNT: Staton Correctional Facility
Prison Health Services
2690 Marion Spillway Road
Elmore AL 36205-0000
ACCOUNT NUMBER: 01308900

TEST	RESULT		LIMITS	LAB
3X Avg.Risk	23.4		11.0	

The CHD Risk is based on the T. Chol/HDL ratio. Other factors affect CHD Risk such as hypertension, smoking, diabetes, severe obesity, and family history of pre-mature CHD.

TEST	RESULT		LIMITS	LAB
Thyroid				
TSH	0.808	uIU/mL	0.350 - 5.500	MB
Thyroxine (T4)	6.8	ug/dL	4.5 - 12.0	MB
T3 Uptake	35	%	24 - 39	MB
Free Thyroxine Index	2.4		1.2 - 4.9	MB
CBC, Platelet Ct, and Diff				
WBC	5.4	x10E3/uL	4.0 - 10.5	MB
RBC	4.91	x10E6/uL	4.10 - 5.60	MB
Hemoglobin	15.0	g/dL	12.5 - 17.0	MB
Hematocrit	43.8	%	36.0 - 50.0	MB
MCV	89	fL	80 - 98	MB
MCH	30.5	pg	27.0 - 34.0	MB
MCHC	34.1	g/dL	32.0 - 36.0	MB
RDW	14.1	%	11.7 - 15.0	MB
Platelets	246	x10E3/uL	140 - 415	MB
Neutrophils	44	%	40 - 74	MB
> Lymphs	47 H	%	14 - 46	MB
Monocytes	6	%	4 - 13	MB
Eos	3	%	0 - 7	MB
Basos	0	%	0 - 3	MB
Neutrophils (Absolute)	2.4	x10E3/uL	1.8 - 7.8	MB
Lymphs (Absolute)	2.5	x10E3/uL	0.7 - 4.5	MB
Monocytes(Absolute)	0.3	x10E3/uL	0.1 - 1.0	MB
Eos (Absolute)	0.2	x10E3/uL	0.0 - 0.4	MB
Baso (Absolute)	0.0	x10E3/uL	0.0 - 0.2	MB

LAB: MB LabCorp Birmingham
1801 First Avenue South, Birmingham, AL 35233-0000
DIRECTOR: John Elgin N MD

****
*** TX REPORT ***
****

TRANSMISSION OK

JOB NO. 0866
DESTINATION ADDRESS 93958156
PSWD/SUBADDRESS
DESTINATION ID
ST. TIME 08/11 15:17
USAGE T 00'54
PGS. 2
RESULT OK

07/17/2006 11:10 FAX 3343958156 REGIONAL OFFICE → STATON 001/001
07/13/2006 THU 14:50 FAX 334 5[illegible] 1538 Staton Health Unit 003/003
07/13/2006 13:54 FAX 3343958156 REGIONAL OFFICE → STATON 003
07/13/2006 THU 12:07 FAX 334 567 1538 Staton Health Unit 003/013

"Please send this form with ... Authorization Letter to the service provider ... of the Appointment

DEMOGRAPHICS

Site Name & Number: 843 - STATON
Patient Name: (Last, First) Fountain, Tony
Date: (mm/dd/yy) 07 03 06
Site Phone #: 334-567-1548
Alias: (Last, First)
Date of Birth: (mm/dd/yy) 8 26 63
Site Fax #: 334-567-7167
Inmate #: 152157 DCC
PHS Custody Date: (mm/dd/yy) 10 18 05
Will there be a charge? ☑ Yes ☐ No
Sex: ☑ Male ☐ Female
SS Number: 416-58-8124
Potential Release Date: (mm/dd/yy) 3 25 07

RECEIVED JUL 2006

Responsible party: ☑ PHS ☐ Auto Ins. ☐ Health Ins. ... ☐ Other, be specific ...

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP/PA ☐ Dental
J. M. Peasant, Sr., M.D.

Facility Medical Director Signature and Date: J. M. Peasant 7/5/06

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☑ Office Visit (OV) ☐ X-ray (xray) ☐ Scheduled Admission (SA)
☐ Outpatient Surgery (OS) ☐ Dialysis (dial)
☐ Routine ☑ Urgent

Estimated Date of Service (mm/dd/yy) ___/___/___
(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy
Number of Visits/Treatments: ___ ☐ Chemotherapy ☐ Other

Specialist referred for:

Type of Consultation, Treatment, Procedure, or Surgery:
Evaluate for ... colonoscopy OFFICE VISIT

Diagnosis: Rectal bleeding
ICD-9 code:

History of Illness/Injury/Symptoms with Date of Onset:
42 y/o BM c/o rectal bleeding off and on for 3-4 months. Ptdenies abd pain, fatigue, or hemorrhoids. No LTD anal intercourse.

Results of a complaint directed physical examination:
Stools Hemo+ 3/21/06 & 6/6/06 on rectal exam.
Prostate 2+ - No hard Nodule
ABN LFTS AST - 44 ALT - 119 7/3/06
Hep A, B, C - all ⊝
Hep ... Ab - Neg - ...

Previous treatment and response (including medications):
08/02/06 Patient taking Nexium ... 20mg QHS
... therapy in past
Dr. Peasant wanted colonoscopy to ...

You must include copies of pertinent records ...

Please send this form with Authorization Letter to the service provider at the ... Must be Complete and Legible. You must Type or P... of the Appointment

PHS

DEMOGRAPHICS

Site Name & Number: 843 - STATON

Site Phone #: 334-567-1548

Site Fax #: 334-567-7167

Will there be a charge? ☑ Yes ☐ No

Sex ☑ Male ☐ Female

Patient Name: (Last, First) Fountain, Tony.

Alias: (Last, First)

Inmate # 152157 DCC

SS Number 416-98-8129

Date: (mm/dd/yy) 07/03/06

Date of Birth: (mm/dd/yy) 8/26/63

PHS Custody Date: (mm/dd/yy) 10/18/05

Potential Release Date: (mm/dd/yy) 3/25/07

Responsible party: ☑ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental

J. M. Peasant, Sr., M.D.

Facility Medical Director Signature and Date: J. M. Peasant 7/3/06

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☑ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)

☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☐ Routine ☑ Urgent

Estimated Date of Service (mm/dd/yy) ___/___/___

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy

Number of Visits/Treatments: _____ ☐ Other:

Specialist referred to:

Type of Consultation, Treatment, Procedure or Surgery: Evaluate & tx c colonoscopy

Diagnosis: Rectal bleeding

ICD-9 code:

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

History of Illness/Injury/symptoms with Date of Onset:

4/20 BM c/o rectal bleeding off and on for 3-4 months

Pt denies abd pain, fissures, or hemorrhoids - No hx of anal intercourse

Results of a complaint directed physical examination:

Stools Hem + 3/21/06 + 6/6/06 on rectal exam.

Prostate 2+ - No hard Nodules

Abn LFTs AST - 64 ALT - 119 7/3/06

Hep A, B, tc - all ⊖

Ast + Alt - WL - 5/24/

Previous treatment and response (including medications):

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Offsite Service Recommended and Authorized

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information.

Date resubmitted: ___/___/___

Regional Medical Director Signature, printed name and date required:

___/___/___ (mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type: Med Class:

CPT code:

UR Auth #:

05a - UM Referral review form

Faxed 7/12/06 JM

"Please send this form wi ... must be Complete and Legible. You must Type or P... Authorization Letter to the service provider at the ... of the Appointment

DEMOGRAPHICS

Site Name & Number: 843 - STATON
Site Phone #: 334-567-1548
Site Fax #: 334-567-7167
Will there be a charge? ☑ Yes ☐ No
Sex: ☑ Male ☐ Female
Patient Name: (Last, First,) Fountain, Tony.
Alias: (Last, First,)
Inmate #: 152157 PCC
SS Number: 416-98-8129
Date: (mm/dd/yy) 07/03/06
Date of Birth: (mm/dd/yy) 8/26/63
PHS Custody Date: (mm/dd/yy) 10/18/05
Potential Release Date: (mm/dd/yy) 3/25/07
Responsible party: - ☑ PHS ☐ Auto Ins. ☐ Health Ins. (Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental
J. M. Peasant, Sr., M.D.
Facility Medical Director Signature and Date: J. M. Peasant Sr 7/3/06
☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.
☐ Office Visit (OV) ☐ X ray (XR) ☐ Scheduled Admission (SA)
☐ Outpatient Surgery (OS) ☐ Dialysis (DIA)
☐ Routine ☑ Urgent
Estimated Date of Service (mm/dd/yy) ___/___/___
(This starts the approval window for the "open authorization period")
Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy
Number of Visits/Treatments: ___ ☐ Other: ___
Specialist referred to:
Type of Consultation, Treatment, Procedure or Surgery: Evaluate for rectal c... colonoscopy OFFSITE
Diagnosis: Rectal bleeding OV Visit
(CD-9 code:
You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.
☐ Pertinent Documents have been attached and faxed.

History of illness/injury/symptoms with Date of Onset:
4/2/06 BM c/o rectal bleeding off and on for 3-4 months
Pt denies abd pain, fissures, or hemorrhoids. No hx anal intercourse

Results of a complaint directed physical examination:
Stools Hem + 3/21/06 + 6/6/06 on rectal exam.
Prostate 2+ - no hard Nodules
ABN LFTs AST - 44 >3/06 ALT - 119
Hep A, B, & C - all (-)
Hgb + Alb - WNL - 3/06

Previous treatment and response (including medications):

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:
☐ Alternative Treatment Plan (explain here):
☐ Offsite Service Recommended and Authorized
☑ More Information Requested: (See Attached) Please clarify are you requesting OV GI referral or the actual colonoscopy procedure?
☐ Resubmitted with requested information. Date resubmitted: ___/___/___
Regional Medical Director Signature, printed name and date required: [signature] 7/12/06

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.
Cert Type: Med Class: CPT code: UR Auth #:

05n - UM Referral review form

Faxed 7/12/06 SM

Please send this form ... must be Complete and Legible. You must Type or P... Authorization Letter to the service provider at ... of the Appointment

PHS

DEMOGRAPHICS

Site Name & Number:	Patient Name: (Last, First,)	Date: (mm/dd/yy)
843 - STATON	Fountain, Tony.	07/03/06
Site Phone #	**Alias: (Last, First,)**	**Date of Birth: (mm/dd/yy)**
334-567-1548		8/26/63
Site Fax #	**Inmate #**	**PHS Custody Date: (mm/dd/yy)**
334-567-7167	152157 DCC	11/15/88
Will there be a charge? ☑ Yes ☐ No / **Sex** ☑ Male ☐ Female	**SS Number** 418-98-7126	**Potential Release Date: (mm/dd/yy)** 12/31/49

Responsible party: – ☑ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental

J. M. Peasant, Sr., M.D.

Facility Medical Director Signature and Date:

J. M. Peasant 7/3/06

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☑ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)
☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☐ Routine ☑ Urgent

Estimated Date of Service (mm/dd/yy) ___/___/___

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy
Number of Visits/Treatments: ____ ☐ Other:

Specialist referred to:

Type of Consultation, Treatment, Procedure or Surgery:
Evaluate & treat c Colonoscopy

Diagnosis: Rectal bleeding
ICD-9 code:

You must include copies of pertinent reports such as lab results, x ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

History of Illness/injury/symptoms with Date of Onset:
4240 BM c/o rectal bleeding off and on for 3-4 months
Pt denies abd pain, fissures, or hemorrhoids - No h/o anal intercourse

Results of a complaint directed physical examination:
Stools Hem + 3/21/06 + 6/6/06 on rectal exam.
Prostate 2+ - No hard Nodules
Abn LFTs AST - 64 > 3/06
ALT - 119
Hep A, B, + C - all (-)
Bili + Alk - WL - 5/241

Previous treatment and response (including medications):

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION: ☐ Offsite Service Recommended and Authorized

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information. Date resubmitted: ___/___/___

Regional Medical Director Signature, printed name and date required:

___/___/___ (mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:	Med Class:	CPT code:	UR Auth #:

Faxed 7/12/06

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

Form must be Complete and Legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

PHS

RECEIVED NOV 03 2005

DEMOGRAPHICS

Site Name & Number: Staton 843

Site Phone #: (334) 567-1548

Site Fax #: (334) 567-1538

Will there be a charge? ☒ Yes ☐ No

Sex: ☒ Male ☐ Female

Patient Name: (Last, First,) Fountain, Tony

Alias: (Last, First,)

Inmate #: 152157 SCC

SS Number: 418-98-7126

Date: (mm/dd/yy) 11/03/05

Date of Birth: (mm/dd/yy) 08/26/63

PHS Custody Date: (mm/dd/yy) 11/15/88

Potential Release Date: (mm/dd/yy) 07/07

Responsible party: ☐ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

CLINICAL DATA

Requesting Provider: ☐ Physician ☐ NP, PA ☐ Dental

J. Beerfeas

Facility Medical Director Signature and Date:

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☒ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)

☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☒ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) ___/___/___

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy

Number of Visits/Treatments: ____ ☐ Other:

Specialist referred to: Dr. Bradford

Type of Consultation, Treatment, Procedure or Surgery:

In house Eye Exam

Diagnosis:

ICD-9 code:

You must include copies of pertinent reports such as lab results, X-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

History of Illness/Injury/symptoms with Date of Onset:

Last Eye Exam 12/22/04

OD 20/25

OS 20/25

OU 20/25

Results of a complaint directed physical examination:

Previous treatment and response (including medications):

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Offsite Service Recommended and Authorized

☒ Alternative Treatment Plan (explain here): Doe not meet S. Kro.

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information.

Date resubmitted: ___/___/___

Regional Medical Director Signature, printed name and date required:

11/3/05 (mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type: Med Class:

CPT code:

UR Auth #:

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

For ...ust be Complete and Legible. You must Type or Print
Please send this form wit... ...e Authorization Letter to the service provider at the ... of the Appointment

PHS

DEMOGRAPHICS

Site Name & Number: Staton 843	Patient Name: (Last, First,) Fountain, Tony	Date: (mm/dd/yy) 11/03/05
Site Phone # (334) 567-1548	Alias: (Last, First,)	Date of Birth: (mm/dd/yy) 08/26/63
Site Fax # (334) 567-1538	Inmate # 152157	PHS Custody Date: (mm/dd/yy) 11/15/88
Will there be a charge? ☒ Yes ☐ No / Sex ☒ Male ☐ Female	SS Number 418-98-7126	Potential Release Date: (mm/dd/yy) 07/__/07

Responsible party: ☐ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):_____

CLINICAL DATA

Requesting Provider: ☐ Physician ☐ NP, PA ☐ Dental

Facility Medical Director Signature and Date:

☐ ~~Service meets criteria for "approval via protocol"~~

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☒ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)
☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☒ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) __/__/__

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy
Number of Visits/Treatments: _____ ☐ Other:_____

Specialist referred to: Dr. Bradford

Type of Consultation, Treatment, Procedure or Surgery:

In house Eye Exam

Diagnosis:

ICD-9 code:

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

History of illness/injury/sypmtoms with Date of Onset:

Last Eye Exam 12/22/04
OD 20/25
OS 20/25
OU 20/25

Results of a complaint directed physical examination:

Previous treatment and response (including medications):

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Offsite Service Recommended and Authorized
☐ Alternative Treatment Plan (explain here):
☐ More Information Requested: (See Attached)
☐ Resubmitted with requested information.

Date resubmitted: __/__/__

FAXED 11/03/05

Regional Medical Director Signature, printed name and date required:

__/__/__ (mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type: / Med Class:	CPT code:	UR Auth #:

Advanced Medical Imaging Center

PLAINTIFF'S EXHIBIT 5

03/22/94

GEORGE S. LYRENE (STATON), M.D.
STATON PRISON
P.O. BOX 56, HWY 143

RE: FOUNTAIN, TONY
Date of Birth: 08/24/63
Patient No: 12637

EXAM: MRI LUMBAR SPINE, WITHOUT CONTR 03/22/94

Dear Dr. Lyrene:

Thank you for referring your patient to Advanced Medical Imaging Center. The findings of my examination are as follows:

The lumbar spine is in good position and alignment. All vertebral bodies have normal height and show normal signal intensity. There are mild degenerative changes of the L4-L5 and L5-S1 discs. There is mild desiccation and dehydration of the disc material, and there is a small herniated disc at the L5-S1 level protruding into the right neural canal near the right neural foramina, possibly causing some nerve root compression on the right side at this level. No other significant findings.

If you have any questions concerning the radiographic findings on this patient, please call me.

Sincerely,

H. PETER JANDER, M.D.

HJ /RL

MEDICAL DIRECTOR'S CONSU[illegible]

NAME: Fountain Donny **AIS:** 152157 **DOB** 8-24-63

DATE: ______ **INSTITUTION:** Easterling **SITE ID:** ______

REFERRED TO: DR Brown **PHONE #** ______

I. Issue (s) addressed: Der not Fibrosa

II. Summary of data: [illegible]
[illegible]
[illegible] derm to fibrosa
Punch biopsy site on
[illegible] Chronic fibrosa
[illegible] no [illegible] needed
[illegible signature]

III. Initial impression / Discussion:

IV. Recommendations:

V. Outside referrals approved:

[signature]

______ Medical Director

______ Site Physician / ______ Rev. Date

For TIMELY PAYMENT,
attach PROVIDER CLAIM copy to your billing and mail to CMS.
Complete MEDICAL RECORD copy and return with Inmate.
Refer to Authorization No on all claims,correspondence,inquires.

AUTHORIZATION NO
T430AS1027

Correctional Medical Systems
Health Services Authorization

Inmate: **FOUNTAIN, TONY** Id: **152157** DOB: **08-24-63** Date: **02-02-95**
Institution: **AL / Staton** Site Id: **T430A**
Referred By: **LYRENE, M.D., GEORGE** Situation: **Not Applicable**

HEALTH SERVICES AUTHORIZED

Extent Of Care: **Consult Only** Location: **Physician Office**
Diagnosis: **CVA**
Code: **436**
Procedure: **Limited Service 0 - 1 hr**
Description:

Provider: **ELMORE COMMUNITY HOSPITAL** Provider No: **1038**
Facility: Facility Id:

HEALTHCARE REPORT **(See Instructions on PROVIDER CLAIM COPY)**

Significant Findings/Tests Completed/Diagnosis:

Treatment Provided:

Orders/Recommendations:

Physician Signature:_____ Date & Time: _____

MEDICAL RECORD COPY
Complete and return with Inmate